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Top Story
- A shoulder for "second victims"

Inside
- Painful lessons

CPA News
- The long quest to end carve-outs

In Brief
- Managing emotional aftershocks
- Ground broken for student residential tower
- Take part in survey on disruptive clinicians
- Flu vaccinations coming soon

- About Us
- Please Write
- Archive

Top Story

A shoulder for "second victims"

A grassroots effort aims to bolster the resources available to Hopkins caregivers who are involved in harmful medical errors.

Several years ago, Laurie Saletnik witnessed how a medical error can devastate not only families and patients, but fellow clinicians as well. After an improperly assembled medical device led to a patient death during a procedure, the Hopkins Hospital assistant director of surgical nursing tried for weeks to comfort a distressed nurse on the patient's care team.

"I called her many times and tried to support her and say, *It's not your fault,*" recalls Saletnik, who also suggested that the nurse speak with a counselor. "I know she heard me and I know she appreciated it, but I felt at a loss. I wasn't sure how to help her."

The seasoned, well-respected nurse returned to the hospital several weeks later, but in a different role.

This past summer, the memory of that experience led Saletnik to join a new Johns Hopkins Medicine committee that hopes to more effectively assist "second victims"—caregivers who are traumatized as the result of unexpected patient death or injury. The Second Victim Committee wants not only to raise awareness of these caregivers' needs, but to leverage existing resources for coping with adverse events, such as the Faculty and Staff Assistance Program (FASAP), and to develop new resources. One of the group's first steps, still taking shape, is training a team of faculty and staff who respond to serious events and help colleagues to heal.

The need is acute, says Albert Wu, a Hopkins internist who delivered a plenary address on second victims at this summer's Johns Hopkins Medicine Patient Safety Summit.

These caregivers may worry that they have lost colleagues' trust. Images from the event can replay in their minds for months. They may have trouble focusing on their clinical duties—increasing the risk of future errors—or experience symptoms of post-traumatic stress disorder, such as hyperactivity, nightmares

and headaches.

Compounding this stress, the culture of medicine treats errors as deviant acts, Wu notes. "In health care, we don't always handle people sensitively or kindly who we perceive as transgressors," he says. "Caregivers internalize those reactions and beat themselves up" if they are involved in errors.

Wu, who coined the term "second victim" in a journal article a decade ago, also speaks on the topic to groups around Hopkins.

"Whenever I give a talk about this, it's inevitable that several people come up to me afterwards and reveal cases that, sometimes, they've been carrying around with them for decades. They say *I've never talked to anyone about this.* And then they relate a heart-rending story."

Need is real

The idea for the committee evolved from discussions with pediatric nurses who still feel pain over the death of 2-year-old Josie King at Hopkins Hospital in 2001 and the publicity that followed it. Risk Manager Jeff Natterman, Patient Safety Director Lori Paine and Director of Pediatric Nursing Shelley Baranowski, who all took part in these talks, recognized the need for a better system to support second victims.

Since they formed the group this year, more than 25 interested people—including physicians, nurses, a medication safety specialist, a chaplain and a FASAP leader—have joined.

"It's not like we've been charged by anybody to do this," Paine says. "This has been a grassroots, whoever's-interested-comes kind of group."

A survey of safety summit participants hinted at the extent of the second victim phenomenon. Of 140 respondents, 60 percent recalled an event in which they were second victims. Among that group, 65 percent reported that, as a result of the incident, they experienced problems such as anxiety, depression or concern about their ability to perform their jobs.

And while roughly half of them received some support—from colleagues, friends or supervisors—44 percent reported getting none at all.

"Although some individual providers do a wonderful job of handling these situations when they come up, it's kind of *ad hoc*," Wu says.

Baranowski, a Second Victim Committee member, says that when a pediatric nurse has been involved in a serious error, the nurse manager often seeks help from palliative care experts or chaplains, if available, or FASAP. While they make use of the resources at hand, more is needed, Baranowski says.

Providing support should happen "as part of our built-in processes, but that's not the way it happens today," she says. "Right now, it depends on who thinks about it."

Baranowski is excited about the committee's concept of trained peer supporters who serve as "first responders to second victims."

"We need the ability for someone to come in—even at 2 in the morning—to meet with a clinician who was involved in a patient injury," Baranowski says.

While few hospitals have such programs, one model exists at University of Missouri Health System, where a network of peer counselors is available around the clock to provide confidential "emotional first aid" to providers following adverse events. A call to a dedicated pager prompts the team to determine the nature of the incident and to identify appropriate peer supporters to respond.

More outreach needed

In addition to developing a similar peer-support infrastructure, Hopkins' Second Victim Committee hopes that an outreach effort will improve knowledge of, and sensitivity to, medical errors' effect on caregivers.

Risk manager Natterman, who often interviews distraught caregivers for his investigations of adverse events, says these clinicians sometimes have severe crises of confidence that can make them question their career paths. He has seen how the attitudes of supervisors—nurse managers or attending physicians, for instance—can profoundly affect how the caregiver reacts to the situation.

"If you have compassionate, motherly or fatherly types of supervisors or nurse managers, it can really make or break whether someone stays in the profession or makes another mistake," he says.

Responses from the recent survey are guiding the committee on its plan of action. For instance, the survey revealed that, of those respondents who identified themselves as second victims, most sought help from colleagues on the unit and, to a slightly lesser extent, managers.

"We need to do more education of people on the front lines to make sure that when they're counseling folks, they know what to say and what to look for," Paine says. "Everyone's afraid of saying something wrong in these situations, so we need to educate people on the right things to say."

– Jamie Manfuso

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